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### AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

I hereby authorize the protected health information regarding the above-named person be exchanged between:

Person/Institution: \_\_\_\_\_ Person/Institution: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Telephone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Information to be used or disclosed is as follows:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Entire Record                          | <input type="checkbox"/> Immunizations  | <input type="checkbox"/> Lab Results       | <input type="checkbox"/> Allergy List     |
| <input type="checkbox"/> Medication List                        | <input type="checkbox"/> Diagnosis List | <input type="checkbox"/> Diagnostic Test   | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Consultation Report                    | <input type="checkbox"/> ER Report      | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Recent History   |
| <input type="checkbox"/> Other ( <i>please specify</i> ): _____ |   |  |   |

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

This information will be used or disclosed for the following purpose:

- Requested by the patient for personal records  
 Sharing with other health care providers for continuing care  
 Other (*please specify*): \_\_\_\_\_

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire on: \_\_\_\_\_

If not otherwise specified this release will expire within 90 days of the date of signature.

I understand that once the above information is disclosed, it may be disclosed again by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**\*\*You must be able to furnish proof of relationship or authority to act for the patient upon request\*\***